Croydon NHS
Primary Care Trust
Clinical Assessment Service

Urticaria

Management

Primary Care management includes

- Studies have shown that detailed history taking with limited laboratory investigations (full blood count, erythrocyte sedimentation rate) is just as effective as extensive laboratory screening in identifying possible causes of urticaria
- Possible screening tests for chronic (>6/52) urticaria include: FBC (eosinophilia may indicate parasite infection); ESR (may be raised in vasculitic urticaria); omission of suspected drugs; if time has been spent in the tropics, a stool sample to check for parasites; Thyroid function tests, including thyroid autoantibodies, may be helpful in identifying existing or potential thyroid disease; the presence of angio-oedema without weals is an indication for checking complement levels
- Treatment with antihistamines, short-course oral corticosteroids

Specialist management includes

- Management of intractable urticaria with longer term steroids or other therapeutic agents.

When to refer

Emergency [discuss with on-call specialist]

- Airway involvement with wheeze: treatment for anaphylaxis should be commenced and the person admitted immediately

In most cases of self-limiting acute urticaria no investigations are needed

Urgent out-patient referral [liaise with specialist and copy to CAS]

- Intractable urticaria not responding to primary care management within 6 weeks.

Refer to CAS

- Acute urticaria thought to be due to a peanut or latex allergy.
- When urticaria is severe or persists beyond 6 weeks with no response to antihistamines.
- If urticarial vasculitis is suspected or there are associated systemic symptoms of the urticaria.
- When there has been angio-oedema affecting the airway, or angio-oedema without weals.

Refer to RARC

- if the patient does not meet the referral criteria above consider referral to CAS requesting a RARC appointment.